EDWARD M. BIRN
Director (Direktot)
BERNADINE C. GINES
Deputy Director (Sigundo Direktot)

DEPARTMENT OF ADMINISTRATION

DIPATTAMENTON ATMENESTRASION

DIRECTOR'S OFFICE
(Ufisinan Direktot)
Telephone (*Telifon*): (671) 475-1101/1250

LOURDES A. LEON GUERRERO
Governor (Maga'håga)
JOSHUA F. TENORIO
Lt. Governor (Sigunda Maga'låhi)

MEMORANDUM

To: Processing Employee

From: Director, Department of Administration

Subject: **Employee Processing**

Buenas yan Håfa Adai! Welcome to the government of Guam! We hope you find employment in the government challenging and rewarding. As a government employee, there are a number of benefits that you may be entitled to. It is also necessary to maintain current and accurate information regarding your employment. There are numerous forms for you to fill out. Please take the time to carefully fill out the attached forms.

Should you have any questions, please do not hesitate to ask for assistance. Again, welcome aboard! Dångkolo na Agradesimiento!

Senseramente,

EDWARD M. BIRN,
Director
Department of Administration

Attachments

GOVERNMENT OF GUAM
(GUBETNOMENTON GUAHAN)
DEPARTMENT OF ADMINISTRATION
(DIPATTAMENTON ATMENESTRASION)
PAYROLL SECTION
(SEKSION SUETO)
Post Office Box 884; Hagåtña, Guam 96932
Tel: (671) 475-1195/1268 – Fax: (671) 472-9794

AUTHORIZATION AGREEMENT FOR AUTOMATIC (DIRECT) DEPOSIT

EMPLOYEE'S NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER
MAILING ADDRESS (PO / ST NAME, CITY, STATE, ZIP)	**DEPT / AGENCY**
EMPLOYEE'S CONTACT NUMBERS	**DEPT. NO.**
WORK: HOME:	

PLEASE CHECK ONE BOX ONLY:

☐ NEW ACCOUNT ☐ CHANGE ACCOUNT ☐ CANCEL ACCOUNT

PAYROLL DIRECT DEPOSIT INFORMATION - ACTIVATION				
Depository Type	Depository Bank Name	ABA Routing No.	Account #	Amount
☒ Checking ☐ Savings	SAMPLE BANK	Always 9 digits :| 123456789 |:	000386XXX	Net Pay Amount
☐ Checking ☐ Savings				NET PAY AMOUNT

The ROUTING NUMBER can be obtained from your financial institution and in most cases it's printed on your check. Incorrect routing number may delay your funds being available to you on the check date. Limited to financial or banking institutions with local branches ONLY.

I hereby authorize the Department of Administration, Payroll Section, to TRANSACT the above effective pay period ending:

EMPLOYEE Signature / Date

BANK REPRESENTATIVE Signature / Date

FOR PAYROLL SECTION USE ONLY			
RECEIVED BY:		PROCESSED BY:	
DATE RECEIVED:		DATE PROCESSED:	

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly or Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . ▶ ☐

TIP: To be accurate, submit a 2022 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each pay period . . 4(c) $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.) ▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2022 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2023.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2022 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2022 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$110	$850	$860	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,770	$1,870
$10,000 - 19,999	110	1,110	1,860	2,060	2,220	2,220	2,220	2,220	2,220	2,970	3,970	4,070
$20,000 - 29,999	850	1,860	2,800	3,000	3,160	3,160	3,160	3,160	3,910	4,910	5,910	6,010
$30,000 - 39,999	860	2,060	3,000	3,200	3,360	3,360	3,360	4,110	5,110	6,110	7,110	7,210
$40,000 - 49,999	1,020	2,220	3,160	3,360	3,520	3,520	4,270	5,270	6,270	7,270	8,270	8,370
$50,000 - 59,999	1,020	2,220	3,160	3,360	3,520	4,270	5,270	6,270	7,270	8,270	9,270	9,370
$60,000 - 69,999	1,020	2,220	3,160	3,360	4,270	5,270	6,270	7,270	8,270	9,270	10,270	10,370
$70,000 - 79,999	1,020	2,220	3,160	4,110	5,270	6,270	7,270	8,270	9,270	10,270	11,270	11,370
$80,000 - 99,999	1,020	2,820	4,760	5,960	7,120	8,120	9,120	10,120	11,120	12,120	13,150	13,450
$100,000 - 149,999	1,870	4,070	6,010	7,210	8,370	9,370	10,510	11,710	12,910	14,110	15,310	15,600
$150,000 - 239,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	16,830
$240,000 - 259,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	15,340	16,540	17,590
$260,000 - 279,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	12,940	14,140	16,100	18,100	19,190
$280,000 - 299,999	2,040	4,440	6,580	7,980	9,340	10,540	11,740	13,700	15,700	17,700	19,700	20,790
$300,000 - 319,999	2,040	4,440	6,580	7,980	9,340	11,300	13,300	15,300	17,300	19,300	21,300	22,390
$320,000 - 364,999	2,100	5,300	8,240	10,440	12,600	14,600	16,600	18,600	20,600	22,600	24,870	26,260
$365,000 - 524,999	2,970	6,470	9,710	12,210	14,670	16,970	19,270	21,570	23,870	26,170	28,470	29,870
$525,000 and over	3,140	6,840	10,280	12,980	15,640	18,140	20,640	23,140	25,640	28,140	30,640	32,240

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$400	$930	$1,020	$1,020	$1,250	$1,870	$1,870	$1,870	$1,870	$1,970	$2,040	$2,040
$10,000 - 19,999	930	1,570	1,660	1,890	2,890	3,510	3,510	3,510	3,610	3,810	3,880	3,880
$20,000 - 29,999	1,020	1,660	1,990	2,990	3,990	4,610	4,610	4,710	4,910	5,110	5,180	5,180
$30,000 - 39,999	1,020	1,890	2,990	3,990	4,990	5,610	5,710	5,910	6,110	6,310	6,380	6,380
$40,000 - 59,999	1,870	3,510	4,610	5,610	6,680	7,500	7,700	7,900	8,100	8,300	8,370	8,370
$60,000 - 79,999	1,870	3,510	4,680	5,880	7,080	7,900	8,100	8,300	8,500	8,700	8,970	9,770
$80,000 - 99,999	1,940	3,780	5,080	6,280	7,480	8,300	8,500	8,700	9,100	10,100	10,970	11,770
$100,000 - 124,999	2,040	3,880	5,180	6,380	7,580	8,400	9,140	10,140	11,140	12,140	13,040	14,140
$125,000 - 149,999	2,040	3,880	5,180	6,520	8,520	10,140	11,140	12,140	13,320	14,620	15,790	16,890
$150,000 - 174,999	2,040	4,420	6,520	8,520	10,520	12,170	13,470	14,770	16,070	17,370	18,540	19,640
$175,000 - 199,999	2,720	5,360	7,460	9,630	11,930	13,860	15,160	16,460	17,760	19,060	20,230	21,330
$200,000 - 249,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$250,000 - 399,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,310
$400,000 - 449,999	2,970	5,920	8,310	10,610	12,910	14,840	16,140	17,440	18,740	20,040	21,210	22,470
$450,000 and over	3,140	6,290	8,880	11,380	13,880	16,010	17,510	19,010	20,510	22,010	23,380	24,680

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$760	$910	$1,020	$1,020	$1,020	$1,190	$1,870	$1,870	$1,870	$2,040	$2,040
$10,000 - 19,999	760	1,820	2,110	2,220	2,220	2,390	3,390	4,070	4,070	4,240	4,440	4,440
$20,000 - 29,999	910	2,110	2,400	2,510	2,680	3,680	4,680	5,360	5,530	5,730	5,930	5,930
$30,000 - 39,999	1,020	2,220	2,510	2,790	3,790	4,790	5,790	6,640	6,840	7,040	7,240	7,240
$40,000 - 59,999	1,020	2,240	3,530	4,640	5,640	6,780	7,980	8,860	9,060	9,260	9,460	9,460
$60,000 - 79,999	1,870	4,070	5,360	6,610	7,810	9,010	10,210	11,090	11,290	11,490	11,690	12,170
$80,000 - 99,999	1,870	4,210	5,700	7,010	8,210	9,410	10,610	11,490	11,690	12,380	13,370	14,170
$100,000 - 124,999	2,040	4,440	5,930	7,240	8,440	9,640	10,860	12,540	13,540	14,540	15,540	16,480
$125,000 - 149,999	2,040	4,440	5,930	7,240	8,860	10,860	12,860	14,540	15,540	16,830	18,130	19,230
$150,000 - 174,999	2,040	4,460	6,750	8,860	10,860	12,860	15,000	16,980	18,280	19,580	20,880	21,980
$175,000 - 199,999	2,720	5,920	8,210	10,320	12,600	14,900	17,200	19,180	20,480	21,780	23,080	24,180
$200,000 - 449,999	2,970	6,470	9,060	11,480	13,780	16,080	18,380	20,360	21,660	22,960	24,250	25,360
$450,000 and over	3,140	6,840	9,630	12,250	14,750	17,250	19,750	21,930	23,430	24,930	26,420	27,730

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Signature of Employee _____ Date _____

Information about Social Security Form SSA-1945
Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 3

Appointment Affidavits

I, _____, do solemnly swear (or affirm) in the presence of Almighty
Name of Employee

God that while employed with _____.
Department

A. OATH OF OFFICE

I will well and faithfully support the Constitution of the United States, the laws of the United States applicable to Guam and the laws of Guam, and that I will conscientiously and impartially discharge my duties as an (officer) (employee) of the government of Guam.

B. AFFIDAVIT AS TO SUBVERSIVE ACTIVITY AND AFFILIATION

I do not advocate nor am I a member of any organization that advocates the overthrow of the Government of the United States or the government of Guam by force or violence or other unconstitutional means or seeking by force or violence to deny other persons their rights under the Constitution of the United States. I do further swear (or affirm) I will not so advocate, nor will I become a member of such organizations during the period that I am an employee of the government of Guam.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not paid, or offered or promised to pay any money or other things of value to any person, firm, or corporation for the use of influence to procure my appointment.

Subscribed and sworn before me this _____ day of _____, _____.

_____
SIGNATURE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised June 15, 2009

ATTACHMENT 4

DESIGNATION OF SURVIVOR OR SURVIVORS FOR PAY WHICH WERE NOT DELIVERED TO EMPLOYEE DURING HIS/HER LIFETIME AND ACCUMULATED UNUSED ANNUAL AND SICK LEAVE UPON DEATH

Pursuant to the provision of Public Law 12-47, approved October 19, 1973, I hereby designate the hereinafter named as survivor or survivors of any amount of pay not delivered to me during my lifetime which may become refundable to me upon my death and for accumulated unused annual and sick leave converted to cash and credited to my account with the government of Guam and hereby authorize, empower and direct employer, government of Guam, to my payments.

Definition of Survivor or Survivors: one who survives another; one who outlives another; one who lives beyond some happening; one or two or more persons who lives after the death of the other or others.

The word "survivors" however, in connection with the power of one or two trustees to act, is used not only with reference to a condition arising where one of such trustees dies, but also as indicating a trustee who continues to administer the trust after his co-trustee is disqualified, has been removed, or refuses to act.

In order to facilitate the settlement of the accounts of deceased employees, money due an employee at time of death shall be paid to the person or persons surviving at the time of death, in the following order of precedence and payment bars recovery by another person of amounts so paid:

FIRST, to the beneficiary or beneficiaries designated by the employee in writing received by the employing department or agency before his death.

SECOND, if there is no designated beneficiary, to the widow or widower of the employee.

THIRD, if none of the above, to the child or children of the employee and descendants of deceased children by representation.

FOURTH, if none of the above, to the duly appointed legal representative of the estate of the employee.

Employee Name _____ Department _____

Social Security Number _____ Position Title _____

Address _____

ELECT OPTION 1 – If your intentions are to designate ONLY ONE survivor/beneficiary

SURVIVOR	SSN	ADDRESS	TELEPHONE NO.	RELATIONSHIP

ELECT OPTION 2 – If your intentions are to designate MORE THAN ONE survivor/beneficiary

SURVIVOR	SSN	ADDRESS	TELEPHONE NO.	RELATIONSHIP	PERCENT-AGE %

_____ _____

EMPLOYEE'S SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 5

Prior Service
(Military and/or Government of Guam)

NAME: _____

MAIDEN NAME OR ANY OTHER
OFFICIAL NAME USED: _____

SOCIAL SECURITY NUMBER: _____

FOR ANNUAL LEAVE CREDIT ONLY

For all Employees hired AFTER APRIL 09, 1998
Only THREE YEARS of Military Service will be credited pursuant to Public Law 24-155

TYPE OF PRIOR SERVICE	DOCUMENT REQUIRED	INDICATE THE YEARS		TOTAL PRIOR SERVICE
		FROM	TO	
Military	DD-214			

TYPE OF PRIOR SERVICE	DOCUMENT REQUIRED	NAME OF DEPARTMENT OR AGENCY	INDICATE THE YEARS	
			FROM	TO
Government of Guam	Copies of Personnel Actions if previously employed			

[ ] NO PRIOR SERVICE

_____ _____
SIGNATURE DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 6

New Employee Master Data Form

1. SOCIAL SECURITY NUMBER: _____

2. LAST NAME: _____
   FIRST NAME: _____
   MIDDLE NAME: _____

3. POSITION TITLE: _____

4. EMPLOYMENT TYPE (circle one):
   P = Probational T = Temporary C = Contract E = Elected
   L = Limited U = Unclassified M = Summer Trainee X = Exempted

5. DATE OF BIRTH: Month _____ Day _____ Year _____

6. SEX (circle one): M = Male F = Female

7. ETHNIC BACKGROUND (circle one):
   CH = Chamorro WH = Caucasian JE = Japanese HI = Hispanic FO = Filipino
   BL = African American MN = Micronesian CE = Chinese KN = Korean VE = Vietnamese
   NM = Northern Marianas OT = Other

8. EMPLOYMENT DATE: Month _____ Day _____ Year _____

9. CITIZENSHIP (circle one):
   1 = U.S. 2 = Alien 3 = Permanent Resident 4 = FSM 5 = Marshall Island

10. SERVICE LENGTH (ONLY FOR PRIOR GOVERNMENT OF GUAM EMPLOYMENT):
    Year _____ Month _____ Day _____

11. MARTIAL STATUS (circle one):
    M = Married D = Divorced W = Widow S = Single L = Legally Separated

12. EDUCATION (circle one):
    GD = GED HS = High School AA = Associate Degree
    BA = Baccalaureate Degree PD = Doctorate Degree MA = Masters
    JD = Juris Doctorate

13. IF MILITARY (circle one):/ No prior service:_____

Prior Active Components

A3 = Army Service
A4 = Prior Active Army Guard
C3 = Prior Coast Guard Reserve
F3 = Prior Air Force Service
F4 = Prior Active Air Force Reserve
M1 = Marines
M3 = Prior Marine Service
N2 = Prior Navy Service

Reserve Components

A1 = Army Guard
A2 = Army Reserve
C1 = Coast Guard
C2 = Coast Guard Reserve
F1 = Air Force Guard
F2 = Air Force Reserve
M2 = Marine Reserve
N1 = Navy Reserve

14. IF VETERAN (circle one): R = Retired D = Discharge

15. PAY GRADE: _____ STEP: _____

16. HOURLY PAY RATE: _____

17. ANNUAL SALARY: _____

18. DISABILITY (circle one): Y = Yes N = No

19. TYPE OF DISABILITY CONDITION:
Hearing Speech Vision Other (specify): _____

20. HOME ADDRESS: _____
(House Number) (Street Number)

CITY: _____ STATE: _____ ZIP CODE: _____

21. MAILING ADDRESS: _____
(Post Office Box or Home Delivery)

CITY: _____ STATE: _____ ZIP CODE: _____

22. TELEPHONE NUMBERS:

HOME	( )				-					
	Area Code									
WORK	( )				-					

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 ATTACHMENT 6

23. POINT OF CONTACT:

NAME: _____

RELATIONSHIP: _____ CONTACT NUMBER: _____

ADDRESS: _____

_____ _____

EMPLOYEE'S SIGNATURE DEPARTMENT

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised February 5, 2008

ATTACHMENT 7

GROUP TERM LIFE INSURANCE PROGRAM

The government of Guam offers to its employees, as part of the government of Guam benefits package, Group Term Life Insurance Program.

BENEFITS	PAYMENT	ELIGIBILITY TIMEFRAME
Basic $10,000	Paid by Government of Guam	After serving 6 months of consecutive service/Entitlement date
Supplemental	Optional/Paid by employee (Refer to brochure)	Within 30 days after serving 6 months
Dependent Coverage	Optional/Paid by employee (Refer to brochure)	Within 30 days after serving 6 months

Yes_____ No_____ Are you a transfer employee from another department/agency?

Yes_____ No_____ Are you also a GovGuam retiree? Department:_____

Which Retirement Plan? Defined Benefit _____ Defined Contribution_____

You are automatically covered for the Basic $10,000 life insurance amount upon serving your six months of service, which is **PAID FOR BY THE GOVERNMENT OF GUAM**. An enrollment form must be completed upon serving your six months of consecutive service (entitlement date).

Your date of hire is _____.

Your entitlement date for the Basic $10,000 insurance is _____.

Within 30 days after your entitlement date, you may elect supplemental/dependent coverage. This 30 days timeframe will end on _____. If you do not make an election for supplemental and/or dependent coverage within 30 days and desire to enroll after, you must complete an Evidence of Insurability form, which is satisfactory to the insurance company before you can become insured or you may enroll during the Open Enrollment Period.

I acknowledge receipt of the "Notification of Eligibility" card which specifies my entitlement date for the Government of Guam Group Life Insurance Program.

I understand that, it is my responsibility to make changes or cancellations to include changes in family status where I no longer have eligible dependents.

You may call your personnel office or the Department of Administration, Human Resources Division at 475-1296/1179 if you have any questions regarding the life insurance program.

_____ _____
EMPLOYEE'S SIGNATURE/PRINT NAME DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised February 5, 2008

ATTACHMENT 8

MEDICAL AND DENTAL INSURANCE AGREEMENT

_____Yes _____No **Do you have other health insurance coverage, to include COBRA?**

_____Yes _____No **Are you a dependent under a spouses (or common-laws) coverage with govGuam? Please note that spouses both employed with govGuam could result in lower premiums.**

_____Yes _____No **Are you also a GovGuam retiree? If so, Department:_____**

I understand that I have 30 days from my effective date of hire to enroll in the health insurance program. Otherwise, I must wait until the next general Open Enrollment Period or a HIPAA event (birth, adoption, marriage, loss of coverage) to elect enrollment. My elections are as follows: (check the appropriate blocks):

[ ] **YES,** I wish to enroll in the GOVERNMENT OF GUAM'S GROUP MEDICAL INSURANCE PROGRAM.
Medical Plan _____

[ ] **NO,** I do not wish to enroll in the GOVERNMENT OF GUAM'S GROUP MEDICAL INSURANCE PROGRAM.

[ ] **I have not made a decision, but understand I have 30 days from my effective date of hire to elect coverage.**

[ ] **YES,** I wish to enroll in the GOVERNMENT OF GUAM'S GROUP DENTAL INSURANCE PROGRAM.
Dental Plan _____

[ ] **NO,** I do not wish to enroll in the GOVERNMENT OF GUAM'S GROUP DENTAL INSURANCE PROGRAM.

[ ] **I have not made a decision, but understand I have 30 days from my effective date of hire to elect coverage.**

I hereby certify that I have been given the opportunity to participate in the government of Guam sponsored Group Health Insurance Programs.

I understand that my rejection of coverage at this time will prevent me from obtaining coverage in the future except during the Open Enrollment Period or upon a qualifying event (HIPAA), i.e. marriage, birth of child, or termination of other coverage.

I hereby certify that in addition to the explanation given to me by the Benefits Branch, Human Resources Division, Department of Administration, I have carefully read all information booklets of each of the plans that are available.

_____ ***CERTAIN HEALTH PLANS HAVE A "LOCK IN PROVISION." EMPLOYEES MAY ONLY CANCEL CERTAIN MEDICAL/DENTAL INSURANCE DURING THE ANNUAL OPEN ENROLLMENT PERIOD.***

_____***RATES MAY INCREASE DURING THE ANNUAL OPEN ENROLLMENT PERIOD. FAILURE TO MAKE CHANGES WILL BE UNDERSTOOD AS A DESIRE TO CONTINUE YOUR EXISTING PLAN AT THE NEW RATE.***

_____ _____
EMPLOYEE'S SIGNATURE/PRINT NAME DATE

_____ _____
WITNESS (Benefits Branch) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised February 5, 2008 **ATTACHMENT 8A**

GOVERNMENT OF GUAM SECTION 125 CAFETERIA PLAN

The Government of Guam offers the Cafeteria Plan pursuant to Section 125 of the Internal Revenue Code. Under this program, you will be able to pay for selected benefits with a portion of your paycheck before income taxes are withheld. This means that you will pay less tax and increase your take home pay. Selected benefits include health insurance, health reimbursement and dependent care assistance.

Employees whose current deduction for medical, dental and life is $20.00 or more will automatically be a participant in the plan unless a form "not to participate" is submitted within 30 days of hire. The administrative fee for eligible employees is $1.00 each pay period and will be automatically deducted from your paycheck. Status will continue unless a form is completed to change selection.

[ ] **Elect to participate** in the Government of Guam Section 125 Cafeteria Plan and have the administrative fee of $1.00 deducted from my pay to maintain my account under the Plan. Status will continue unless ineligible (deductions are below $20.00) or a form is completed to revoke prior selection.

[ ] **Elect not to participate** in the Government of Guam Section 125 Cafeteria Plan. A form "not to participate" must be completed within 30 days of hire. May opt to enroll during the Open Enrollment Period.

If a Form "not" to participate is **not completed**, you will automatically be in the Plan during the Annual Cafeteria Plan Open Enrollment Period, upon qualifications.

_____ _____

EMPLOYEE SIGNATURE/PRINT NAME DATE

_____ _____

WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised February 5, 2008 ATTACHMENT 9

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law by President Clinton on August 21 1996.

This law was designed to help employees who are enrolled in a health plan maintain access to health insurance coverage as they change employers or when they leave their employer and seek an individual health plan. Compliance requirements are placed on employer-sponsored group health plan, insurance companies and health maintenance organizations.

An important aspect of the HIPAA (effective June 1, 1997), is the "Certificate of Coverage" that is issued by the health plan(s). This Certificate is important in the event an employee terminates from a group health plan. The Certificate will provide evidence of continuous creditable coverage of 18 months or more, if applicable, to avoid any pre-existing condition exclusion. The Certificate will assist you in obtaining coverage for you and your family when you loose it as a result of the following:

- Upon termination/resignation
- When I cancel my group health insurance with the government of Guam

As an employee, I understand that by completing the proper documents, the government will inform the health plan in which I am enrolled with as a result of the above.

In addition, if a "Certificate of Coverage" is not provided to me, it is my responsibility to inform the Human Resources Division, Department of Administration.

This is to certify that I have read and understood my rights under the HIPAA as explained and provided by the Benefits Branch, Human Resources Division, Department of Administration.

_____ _____
SIGNATURE/PRINT NAME DATE

_____ _____
WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised February 5, 2008 ATTACHMENT 10

ACKNOWLEDGEMENT OF INSURANCE PREMIUM OBLIGATION WHILE ON APPROVED LEAVE WITHOUT PAY STATUS/MILITARY LEAVE WITHOUT PAY

I understand that, while I am on **Approved Leave Without Pay (LWOP)** status (sick and/or annual leave), I am personally responsible for paying both the government and employee bi-weekly premium(s) for the Group Medical and Dental Insurance. I also understand that failure on my part to pay the premium(s) due while on Approved Leave Without Pay may result in denial of claims against the insurance company.

I am responsible for payment for any supplemental and/or dependent coverage. The government of Guam will contribute its share of the basic premium cost for the life insurance program and will make such payment on a bi-weekly basis. I understand that payments are made directly to the Insurance Company.

However, should I invoke leave under the Family Medical Leave Act of 1993, I understand I will be responsible to pay my premium only. In the event, I do not return to work after invoking the Family Medical Leave Act of 1993, I will pay back the government's contribution for my insurance.

In the event I am on military leave without pay and I do not cancel my insurance coverage, the government of Guam will continue both the employee and employer share for both the health and life insurance program. Deductions will continue under my payroll upon my return. If I shall miss the Annual Open Enrollment Period, and upon my return, I have the opportunity to make any appropriate changes. I must notify my Personnel Office of any desire to change plans.

_____ _____

EMPLOYEE SIGNATURE/PRINT NAME DATE

_____ _____

WITNESS (Benefits Branch Only) DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008

ATTACHMENT 11

Retirement Defined Contribution and Defined Benefit Plan

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF HIRE

Pursuant to Public Law 28-141 Section 3 (d), an employee whose employment commences after October 1, 2005 and whose employment is purely temporary, seasonal, intermittent or part-time shall be a member of the Defined Contribution Retirement System unless the employee is eligible for re-admission to the existing retirement system.

Pursuant to Public Law 23-42, all new employees of the government of Guam who's employment commences on or after October 01, 1995, must participate in the Defined Contribution Retirement System as a condition of employment.

1. Have you had any prior service with the government of Guam before October 01, 1995.

   [ ] YES [ ] NO

   NOTE: **IF NO, THEN YOU BELONG TO THE DEFINED CONTRIBUTION PLAN.**

2. If yes, did you withdraw your retirement contribution?

   [ ] YES [ ] NO

   NOTE: **IF YES, THEN YOU BELONG TO THE DEFINED CONTRIBUTION (DC) PLAN.**
   IF NO, THEN YOU BELONG TO THE DEFINED BENEFIT (DB) PLAN.

With my signature below I certify that I was informed by the Department of Administration, Human Resources Division, to process with the Government of Guam Retirement Fund.

EMPLOYEE'S SIGNATURE

DATE

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised January, 2018

ATTACHMENT 12

Government of Guam Retirement Plan Determination

PLEASE COMPLETE THE FOLLOWING AND REQUEST FOR VERIFICATION FROM RETIREMENT FUND			
EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DATE OF HIRE

FOR THE GOVERNMENT OF GUAM RETIRMENT FUND USE ONLY

The above employee is eligible to participate in one of the following Government of Guam retirement plans:

[ ] Defined Benefit (DB) Plan

[ ] Defined Contribution (DC) Plan

[ ] Defined Benefit 1.75 (DB 1.75) Plan

[ ] Guam Retirement Security Plan (GRSP)

VERIFICATION MADE BY:

PRINT NAME

SIGNATURE

DATE

UPON COMPLETION, PLEASE RETURN THIS FORM TO THE DEPARTMENT OF ADMINISTRATION, HUMAN RESOURCES DIVISION, RECORDS BRANCH.

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 13**

Report of Medical Examination – Retirement Copy

THIS REPORT OF MEDICAL EXAMINATION MUST BE COMPLETED AND SUBMITTED WITHIN 60 DAYS OF YOUR EFFECTIVE DATE OF HIRE. FAILURE TO DO SO IS SUBJECT TO TERMINATION.

1. DEPARTMENT:		2. DATE OF EXAM:
3. NAME:		4. SOCIAL SECURITY NO.:
5. SEX: M F	6. DATE OF BIRTH:	7. PLACE OF BIRTH:
8. ADDRESS (Number, Street, or RFD, City, State):		
9. NEXT OF KIN (Please indicate address and relationship):		
10. RACE:	11. CURRENT POSITION TITLE:	

ITEMS BELOW ARE TO BE COMPLETED BY HEALTH CARE PROFESSIONALS ONLY

12. HEARING: RT LT	13. VISION: RT 20/CORRECT TO 20/20: LT 20/CORRECT TO 20/20:	14. BUILD [ ] Slender [ ] Heavy [ ] Medium [ ] Obese
15. TEMPERATURE:	16. PULSE:	
17. RESPIRATION:	18. BLOOD PRESSURE:	
19. HEIGHT:	20. WEIGHT:	
21. HAIR COLOR:	22. EYE COLOR:	

CLINICIAN: Please check appropriate box and describe any abnormality as applicable

AREA OF EXAMINATION	NORMAL	ABNORMAL	NOT EXAMINED	DESCRITION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS				
26. EYES – GENERAL				
27. OPTHALMOSCOPIC				
28. NECK				
29. CHEST				
30. LUNGS				
31. BREASTS				
32. HEART				
33. VASCULAR SYSTEM				
34. ABDOMEN				
35. ANUS, RECTUM				

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 13**

Report of Medical Examination – Retirement Copy

36. GENITALIA				
37. UPPER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
38. LOWER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
39. SPINE & OTHER MUSCULOSKELETAL				
40. IDENTIFICATIONS, SCARS, BODY MARKS, TATTOOS				
41. SKIN				
42. PELVIC/PAP (Females Only)				
43. PROSTATE (Males Only)				

ALL ITEMS BELOW THIS LINE ARE TO BE COMPLETED BY PHYSICIAN

44. PPD DATE: RESULTS:	45. IMMUNIZATIONS:

46. OTHER TESTS: **Only if Indicated**

a. CBC (No Differential)	d. Hemoccult	g. Chest X-Ray
b. Fasting Blood Sugar	e. Hepatitis Screening	h. Other
c. Urinalysis	f. Cholesterol	

47. REMARKS: Clinical Evaluation Comments, Recommendations, Summary of Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

48. RESULTS ON THE BASIS OF THIS EXAMINATION:

[ ] Is physically fit for this position.

[ ] is NOT physically fit for this position.

49. PRINT NAME OF EXAMINING PHYSICIAN

50. SIGNATURE OF EXAMINING PHYSICIAN	51. DATE

52. ADDRESS OF EXAMINING PHYSICIAN (Number, Street, or RFD City, State)

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 14**

Report of Medical Examination – Human Resources Division

THIS REPORT OF MEDICAL EXAMINATION MUST BE COMPLETED AND SUBMITTED WITHIN 30 DAYS OF YOUR EFFECTIVE DATE OF HIRE. FAILURE TO DO SO IS SUBJECT TO TERMINATION.

DUE DATE: _____ **ISSUE DATE:** _____

1. DEPARTMENT:		2. DATE OF EXAM:
3. NAME:		4. SOCIAL SECURITY NO.:
5. SEX: M F	6. DATE OF BIRTH:	7. PLACE OF BIRTH:
8. ADDRESS (Number, Street, or RFD, City, State):		
9. NEXT OF KIN (Please indicate address and relationship):		
10. RACE:	11. CURRENT POSITION TITLE:	

ITEMS BELOW ARE TO BE COMPLETED BY HEALTH CARE PROFESSIONALS ONLY

12. HEARING: RT LT	13. VISION: RT 20/CORRECT TO 20/20: LT 20/CORRECT TO 20/20:	14. BUILD [ ] Slender [ ] Heavy [ ] Medium [ ] Obese
15. TEMPERATURE:		16. PULSE:
17. RESPIRATION:		18. BLOOD PRESSURE:
19. HEIGHT:		20. WEIGHT:
21. HAIR COLOR:		22. EYE COLOR:

CLINICIAN: Please check appropriate box and describe any abnormality as applicable

AREA OF EXAMINATION	NORMAL	ABNORMAL	NOT EXAMINED	DESCRITION OF ABNORMALITY
23. HEAD, FACE SCALP				
24. NOSE, MOUTH, THROAT				
25. EARS				
26. EYES – GENERAL				
27. OPTHALMOSCOPIC				
28. NECK				
29. CHEST				
30. LUNGS				
31. BREASTS				
32. HEART				
33. VASCULAR SYSTEM				
34. ABDOMEN				
35. ANUS, RECTUM				

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 14**

Report of Medical Examination – Human Resources Division

36. GENITALIA				
37. UPPER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
38. LOWER EXTREMITIES (Strength, Range of Motion, Peripheral Pulses)				
39. SPINE & OTHER MUSCULOSKELETAL				
40. IDENTIFICATIONS, SCARS, BODY MARKS, TATTOOS				
41. SKIN				
42. PELVIC/PAP (Females Only)				
43. PROSTATE (Males Only)				

ALL ITEMS BELOW THIS LINE ARE TO BE COMPLETED BY PHYSICIAN

44. PPD DATE: RESULTS:	45. IMMUNIZATIONS:

46. OTHER TESTS: **Only if Indicated**

a. CBC (No Differential)	d. Hemoccult	g. Chest X-Ray
b. Fasting Blood Sugar	e. Hepatitis Screening	h. Other
c. Urinalysis	f. Cholesterol	

47. REMARKS: Clinical Evaluation Comments, Recommendations, Summary of Physical Defects & Diagnosis: (Use additional sheets of plain paper if necessary)

48. RESULTS ON THE BASIS OF THIS EXAMINATION:

[ ] Is physically fit for this position.

[ ] Is NOT physically fit for this position.

49. PRINT NAME OF EXAMINING PHYSICIAN

50. SIGNATURE OF EXAMINING PHYSICIAN	51. DATE

52. ADDRESS OF EXAMINING PHYSICIAN (Number, Street, or RFD City, State)

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008 **ATTACHMENT 15**

Acknowledgement of General Notice of Drug Free Workplace Program

I acknowledge that the Government of Guam promotes a Drug Free Workplace Policy (DFWP). Upon request, I can obtain a copy of the DFWP. I understand that I may be selected for random drug testing, and also tested when there is reasonable suspicion to believe that I may be using drugs, or as a result of a safety mishap, or as part of a follow-up to rehabilitation. I also understand that refusal to submit to testing will result in discipline, up to and including dismissal.

Name of Employee: _____

Social Security Number: _____

Department/Agency: _____

Signature: _____

Date: _____

GOVERNMENT OF GUAM
DEPARTMENT OF ADMINISTRATION
HUMAN RESOURCES DIVISION

Revised May 16, 2008

ATTACHMENT 16

Employee Processing Form Checklist

Please initial alongside the space for which you filled out the appropriate documents

ATTACHMENTS	DOCUMENT NAME	INITIALS
1	Department of Treasury Internal Revenue Service (Form W-4)	
2	Employment Eligibility Verification (I-9 Form) and List of Acceptable Documents	
3	Appointment Affidavits	
4	Designation of Survivor or Survivors (Unused Annual and Sick Leave Upon Death)	
5	Prior Service	
6	New Employee Master Data Form	
7	Group Term Life Insurance Program	
8	Medical and Dental Insurance Agreement	
9	Health Insurance Portability and Accountability Act (HIPAA)	
10	Acknowledgement of Insurance Premium Obligation While on Leave Without Pay Status	
11	Retirement Defined Contribution and Defined Benefit Plan – Questionnaire	
12	Retirement Defined Contribution and Defined Benefit Plan – Retirement Verification	
13	Report of Medical Examination – Retirement Copy	
14	Report of Medical Examination – Human Resources Division Copy	
15	Acknowledgement of General Notice of Drug Free Workplace Program	
16	Employee Processing Form Checklist	

I hereby certify that I have carefully reviewed and understand the attachments listed above, and that there were no missing attachments from the Employee Processing Form.

_____
SIGNATURE

_____
DATE